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In New Lawsuit, Health Insurers Allege Fraud and Kickbacks Against Out-of-Network Providers Who Forgive Patients' Financial Responsibility

Health insurers have long challenged the efforts of out-of-network providers to increase patient volume by waiving or forgiving the patient's coinsurance, deductible or other financial obligation. Until recently, we have seen that health insurers were mostly content to limit their challenge to not paying the providers' billed charges, or claiming subsequent overpayments. Litigation on the issue was rare. However, in a significant shot across the bow in the ongoing struggle between health insurers and out-of-network providers over payment, Aetna has sued seven California surgery centers for an alleged fraudulent billing scheme that it claims to be illegally striking at the very financial core of Aetna's managed care network. Regardless of whether Aetna ultimately prevails, the case promises to have significant repercussions for the out-of-network provider community.

The lawsuit, *Aetna Life Insurance Co. v. Bay Area Surgical Management LLC*, case no. 112CV217943, filed on February 2, 2012 in Santa Clara County Superior Court, alleges that the surgery centers illegally induced its physician investors, who are in-network with Aetna, to refer their patients to the surgery centers with promises that the patients would not have any financial responsibility to the surgery centers for their out-of-network coinsurance and deductibles. Aetna claims that the surgery centers then turned around and submitted charges for reimbursement that were artificially inflated, because they are much greater than the amount the facility expects to be paid…, which is reflected by the fact that the facility does not collect those charges from the member. Aetna alleges that this type of billing scheme drives up the cost of health insurance coverage, because by not having any skin in the game, patients have no incentive to become better educated about the true costs of their healthcare.

From the health insurers' perspective, when a provider routinely waives the patient's financial obligation for receiving out-of-network coverage, the provider's bill reflecting a percentage of the provider's reasonable and customary charge is a phantom number. For example, in one example listed in Aetna's complaint, a patient who received a bunion repair was responsible for a 20% coinsurance portion pursuant to the terms of the patient's benefit plan. Instead of charging Aetna a reasonable and customary charge minus the patient's 20% coinsurance, the surgery center waived the coinsurance and submitted its full billed charge to Aetna – in the amount of $66,100 – with the expectation that Aetna would pay 80% of that total amount.

Although courts have previously ruled that health insurers are not obligated to reimburse the provider who routinely waives coinsurance in the manner described above, Aetna's lawsuit raises the stakes considerably because it alleges that providers are liable for engaging in a fraudulent and illegal kickback scheme whenever they forgive a patient's coinsurance and deductible amounts, even if the provider bills the patient but ultimately does not collect from the patient. Aetna is asking the court to require the surgery centers to pay damages, to disgorge their profits, and to pay for Aetna's attorneys fees. Furthermore, Aetna wants the court to issue an injunction preventing the surgery centers from continuing their practice of relieving patients from paying their portion of the out-of-network provider's charge, and also to declare that such fee-forgiving practices are illegal.

It remains to be seen whether Aetna's theories of liability against the surgery centers will hold up in court. Many years ago the California Attorney General issued an opinion in which it determined that a provider's practice of waiving copays was not fraudulent.[1] Moreover, as health insurers increasingly move away from a usual, customary and reasonable standard for reimbursement, and towards paying based on a maximum allowable amount that is pre-determined, the charges represented by a provider in a claim arguably are not relied on by the health insurer in making payment, and therefore cannot be the basis of a claim for fraud.

In any event, out-of-network providers should be concerned that health insurers might use aggressive litigation tactics to challenge any type of discount arrangement that the health insurer does not like, even if it is designed simply to avoid the unsavory process of sending patients to collections. In a time of increasing scrutiny on providers' charges, out-of-network providers should review their practices, their contracts with patients and other aspects of their health insurance billings to ensure that they are legally compliant and defensible against a health insurer's lawsuit. Nelson Hardiman regularly advises and litigates on behalf of health care providers on reimbursement and managed care issues.

[1] 64 Ops. Cal. Atty. Gen. 782 (1981).

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